Application to State Chronic Renal Disease Program

Return completed form to:
Illinois Department of Public Aid
P.O Box 19129
Springfield, Illinois 62794-9129
(217) 782-5565

State Renal Number (9-digit) 97 _____

Please Complete Every Blank on Front and Back

Patient's Name (Mr., Mrs., Miss) _____ (First) _____ (Middle) _____ (Last)

Patient's Address _____ (Number, Street, R.R.) _____ (City) _____ (State) _____ (Zip Code) _____ (County)

Social Security Number _____ Date of Birth _____ (Mo Day Year) Telephone Number _____

Sex: Male ☐ Female ☐ Race: White ☐ Black ☐ Other ☐ (Specify) _____

Date of First Chronic Dialysis _____ Date of Transplantation (leave blank if N/A) _____

Name of Dialysis Facility _____ Facility's Medicaid Number _____

Medicare Status: Uncovered _____ Pending _____ Effective Date Covered _____

Treatment Modality and Location: Staff Assisted ☐ Self Care ☐ Home ☐ Hemodialysis ☐ Peritoneal ☐

Members of Family Living in Household, Including Patient - List Head of Household First		
Name	Age	Relationship to Patient
1.		
2.		
3.		
4.		
5.		
6.		

Hospital and Medical Care Insurance Only		
Insurance Company Name	Policy Holder	Policy Number Group - Individual
Hospital:		
Medical:		

Total annual premium(s) paid by family for this insurance $ _____

Insurance pays towards out-patient dialysis: Yes ☐ No ☐

Other Special information regarding your insurance coverage _____

Public Assistance Case Number _____ Effective Date (mm/dd/yyyy) _____

Patient does not qualify for Public Aid because _____

Signed _____ (Social Worker or Financial Rep.)

Important Notice

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Public Act 83-99. Disclosure of this information is mandatory. This form has been approved by the Form Management Center.

Patient and members of family living at home - employed during past year. If patient is a minor, include parent's or guardian's income.				
Name	Place of Employment	Annual Income During Past Year	Current Monthly Income	If Currently Unemployed, State Why and Last Day of Employment
		0.00	0.00	

Attach copies of your most recent Federal Income Tax Return (1040 or 1040A) and Illinois Income Tax Return (1040) including all supplementary forms. Notes:

Other Income During Past Year

1. Unemployment Compensation $ ____ x ____ months, or $ 0.00 Total
2. Disability or Pension $ ____ x ____ months, or $ 0.00 Total
3. Social Security $ ____ x ____ months, or $ 0.00 Total
4. Other ____ $ ____ x ____ months, or $ 0.00 Total

(Specify)

$0.00

Necessary and Unavoidable Expenditures

1. Special care for children (Explain) ____ $ ____
2. Support (Relative or alimony) ____ $ ____
3. Retirement or Social Security (Explain) ____ $ ____
4. Employment expense (Union Dues, Special Clothing &Tools) ____ $ ____
5. Transportation for dialysis ____ $ ____
6. Other (Explain) ____ $ ____

$0.00

Family Medical Care Costs During Past 12 Months (Including Patient)								
Name	Describe Medical or Dental Needs	Dollar Amount of Costs				Total Paid By Insurance	Total Paid By Family	Total Owed
		Physician	Dentist	Hospital	Drugs			
Totals:		0.00	0.00	0.00	0.00	0.00	0.00	0.00

Special Information

I hereby certify that the answers given on this application and financial profile are correct and true to the best by my knowledge. I authorize the Illinois Department of Public Aid, or its representative to verify all facts herein stated relative to any financial condition or income. It is understood that all information will be treated as confidential.

Date (mm/dd/yyyy)____ Signed ____

(If Additional Space is Needed, Attach Supplement)